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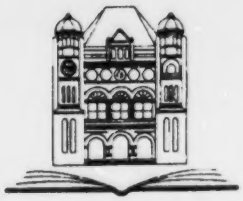

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HOSPITAL RESTRUCTURING IN ONTARIO

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INTRODUCTION

The Ontario government created the Health Services Restructuring Commission (HSRC) in March 1996. The Commission's role was to expedite hospital restructuring in the province and to advise the Minister of Health on revamping other aspects of Ontario's health services system.[1] By the end of its mandate, the HSRC issued final directions to 22 communities affecting 110 hospitals. These directions amalgamated 45 hospitals into 13 and closed 29 hospital sites. The Commission directed hospitals to undertake $2.1 billion in capital projects, and recommended that the Ministry invest $1.1 billion in community resources.[2] On March 29, 2000, Ontario's Health Services Restructuring Commission completed its four year mandate. This backgrounder highlights the hospital restructuring component of the Commission's work over that four year period.

BACKGROUND

As early as 1981, District Health Councils (DHC) in several Ontario communities commissioned studies to assess overlap and duplication of services among local hospitals. Merger discussions took place over a number of years. By the early 1990s, similar initiatives were well underway in many Ontario communities. Local planning studies concluded that in an era of budgetary constraints, there were inefficiencies associated with multiple acute care hospitals Moreover, in larger cities, emerging trends such as reduction of in-patient days, increased ambulatory care and day surgery called out for a system-wide examination to highlight strengths, weaknesses, gaps and lack of co-ordination in service delivery. As the publication of these studies, analyses, and DHC recommendations accumulated, community after community recognized that they were squarely in the forefront of health care restructuring in Ontario. The largest planning process has been in metropolitan Toronto, where in 1995, a committee of the Metropolitan Toronto DHC released its recommendations on restructuring the local system of 44 hospitals.[3]

In June 1995 a provincial election brought the Conservatives to office in Ontario after a 10 years absence. On November 29th of that year, Finance Minister, Ernie Eves delivered an *Economic Statement* to the Legislature. What Ontarians wanted, according to the Finance Minister, was "a sound and affordable health care system." He spoke of the need to find savings in some areas in order to meet needs in others: the requirements of an aging population, new technologies, shorter waiting lists, etc. To find additional health care savings, he urged hospitals to continue their restructuring efforts.

> Hospitals must continue to restructure. The former government closed 6,700 acute-care beds over the past five years. That is the equivalent of 30 medium-sized hospitals, but of course 30 medium-sized hospitals were not closed. That has left a hospital system that is in may ways inefficient and hard to manage. . .

To assist hospitals to restructure further, Mr. Eves noted that the Minister of Health, Jim Wilson would establish a Health Services Restructuring Commission (HSRC) to manage and accelerate the implementation of hospital restructuring regionally and locally. The Finance Minister further stated that the government would re-direct funds away from hospitals over three years. Hospital transfers would be reduced by $365 million (or 5%) in 96-7, $435 million (or 6%) in 97-8 and $507 million (or 7%) in 98-9. (The hospital funding constraints for the third year were subsequently cancelled.)[4] Reaction from the Opposition was swift and not surprisingly, highly critical.

THE HEALTH SERVICES RESTRUCTURING COMMISSION

The mandate of the Health Services Restructuring Commission was spelled out in Bill 26, the *Savings and Restructuring Act, 1995*, an omnibus bill which was given First Reading on November 29, 1995, the same day as Mr. Eves' *Economic Statement*. The provision relating to the Health Service Restructuring Commission (HSRC), repealed a section of the *Ministry of Health Act* establishing the advisory Ontario Council of Health, and replaced it with a provision establishing the HSRC. The Act's explanatory notes described the commission as "a corporation without share capital and is given authority to carry out any duties assigned to it under the *Ministry of Health Act* or any other Act." Thus, the commission's mandate flowed from legislation within Bill 26, and from regulations issued under the *Ministry of Health Act* and the *Public Hospitals Act*.

A Ministry of Health *Backgrounder* on the subject of hospital restructuring issued in November 1995 laid out the objectives of hospital restructuring as follows:

- Ensure quality care continues to be available to Ontarians
- Focus resources on front line patient care
- Eliminate waste and duplication
- Improve the use of existing resources
- Integrate delivery of local services to ensure that people's needs are met in the most efficient and effective way possible

In addition to the creation of the HSRC, the government provided hospitals with "a set of tools" the hospitals requested to assist the sector with restructuring.[5]

At an Insight Conference on Health Care Services held in March 1996, two weeks after the Commissioners were appointed, an advisor to the Commission explained the role and broad mandate of the HSRC.

> First a key caveat: the Health Services Restructuring Commission is not simply a hospital restructuring commission. The chair, and I suspect most of the Commissioners, anticipate a wider-angle view of the health system. One cannot consider hospitals in isolation from community and social services, including home care programs; one cannot consider acute care

> hospitals in isolation from chronic and rehabilitative institutions. Indeed it is hard to know where to draw the line. Physicians, for example, are key resource allocators and leaders within public hospitals. The organization of ambulatory and primary care has a major bearing on the use of hospital resources. . . [6]

The Commission's hope for its role, he explained, was to facilitate and accelerate the implementation of hospital restructuring as determined locally.

> I am sure that few things would make the Commissioners happier than finding district after district where restructuring as recommended by the district health council has been accepted by the affected players, where analyses by the Ministry of Health concur with local opinions, where the capital requirements needed to support local restructuring are modest and defensible, and where movement toward restructuring is voluntary, locally-initiated, and already underway.[7]

In April 1996, just as the Commissioners were beginning their work, a want of confidence motion was debated in the Ontario Legislature. While the debate reiterated many of the concerns expressed during public hearings on the health provisions of Bill 26, some Members expressed concern about commencing a restructuring process with a $1.3 billion dollar cut from hospital funding and possible losses of 20–26,000 health sector jobs. In response, government members argued that health care dollars had been reinvested in kidney dialysis, cardiac care, the emergency room crisis, community-based long-term care as well as the operating costs of Magnetic Resonance Imaging (MRIs).

HSRC Mandate – Phase I

The HSRC was provided with the authority to issue legally binding directions to hospitals and to promote compliance. Not all HSRC directions have been accepted by the hospital(s), stakeholders and local communities. A few disputes over HSRC directions have had to be resolved through negotiations, facilitators and finally, through the courts.

Hospital restructuring has created much anxiety among many Ontarians.[8] On February 27, 1997, an Ontario MPP moved a Private Member's motion which asked the government to stop cutting hospital base funding and ensure that community services are in place before any hospitals are closed or merged by the HSRC.

Between 1996 and 1999 the HSRC directed that 33 public hospital sites no longer be used as hospitals (although some would be converted into ambulatory care centres or nursing homes). In addition, the HSRC recommended that six psychiatric hospital sites and six private hospital sites be closed. In the Commission's view, all of the hospitals that the HSRC had examined over the past three years required renovations. The HSRC estimated that over $2 billion in renovations, would, when completed, expand capacity so

that hospitals could handle 17 % more emergency room visits and 18 % more ambulatory care visits.[9] Recognising the growing needs of an aging population for cancer and cardiac services, the HSRC called for the construction of four new regional cancer centres, a cancer treatment satellite site and a new cardiac surgery centre.

In early April 1998, Duncan Sinclair, Chair of the HSRC said: "Hospital restructuring and reinvestments have got to go together. In fact, reinvestment has to occur before hospitals move ahead with restructuring."[10] Later that month, the HSRC issued, Change and Transition, planning guidelines that called for a $900 million annual reinvestment in home care, long-term care, mental health and rehabilitation. He urged the government to make these reinvestments over the next two years.[11]

In addition to addressing duplication among hospitals, the HSRC recognized that northern rural and remote hospitals would have to be treated differently from urban hospitals . Health Minister Jim Wilson released his government's *Rural and Northern Health Care Framework* in June 1997. A key element of the framework was to ensure that residents of rural and northern Ontario had 24-hour access to care, with links to more specialized health care addressed by the creation of rural and northern health networks.[12] The Ministry proposed that hospitals no longer operate in isolation, but cluster together to support each other, share resources, and then move toward integration with community and other health care providers. Where possible, rural hospitals would be encouraged to share administrative, support, clinical and medical staff and to also explore opportunities for common governance. The Ministry developed the framework with a panel of experts to provide guidelines for the delivery of health services in rural and northern areas. The province's 33 District Health Councils were designated to take the lead on implementing the framework in co-operation with hospitals and other health care providers.[13] On March 8, 1999, the HSRC released its plans to increase collaboration among rural and northern hospitals into18 networks that include 90 Ontario hospitals. In 2000, the networks will be expected to implement their service plans.

The Commission's summary report to the Minister of Health on the hospital restructuring phase of their mandate was submitted in April 1999.[14] Duncan Sinclair, Chair, noted that the following five key outcomes of hospital restructuring were expected to be in place by 2003.

1. Urban hospitals would be consolidated into larger organizations on fewer sites.
2. Rural and northern hospitals would be reorganized into networks.
3. Patients now occupying hospital acute care beds would have access to home care, long-term care, rehabilitation, mental health and sub-acute care.
4. Capacity would be improved for specialized services such as MRIs, hip and knee replacements, cardiac surgery and radiation therapy for cancer patients.
5. Hospital buildings would be renewed and many new community-based facilities created.

In all of this, the chair of the HSRC emphasized cost effectiveness, accessible services, and higher quality patient care. In addition, the Commission recommended a $1.2 billion

annual reinvestment in health services. The funding would add 17,000 more beds to nursing homes and homes for the aged; 25,000 more long-term care places in community settings; allow 80,000 more patients to be helped to continue recovering from an acute care hospital stay at home; and create 1,600 new sub-acute care beds in hospital.[15]

HSRC Mandate – Phase II

The Chair notedthat between April 1999 and the end of the Commission's mandate in March 2000, the HSRC would be preparing advice to the Minister on ways to achieve greater co-ordination among the many contributors in the health care system. During this time, the HSRC worked on several reports related to Phase II of its mandate. In February 1999, the Commission prepared advice to the Minister on *Building a Community Mental Health System in Ontario*. In June 1999 the Commission submitted advice and recommendations to the Minister on *An Ontario Health Information Management Action Plan*. In November 1999, the Commission released its *Primary Health Care Strategy*, a detailed action plan to create a system of primary health care in Ontario. The commission also prepared a paper entitled: *Implementing Integrated Health Systems in Ontario*, and defined the next steps in health system reform in a paper entitled: *From here to where?*

Following the provincial election held June 3rd 1999, Elizabeth Witmer was re-appointed Minister of Health with additional responsibilities for Long-Term Care. The Provincial Auditor released his *Annual Report* in mid-November; part of the report's section on the Ministry of Health and Long-Term Care dealt with hospital restructuring. The Auditor reiterated that the HSRC had directed Ontario hospitals to undertake capital projects totalling an estimated $2.1 billion; had recommended that the Ministry invest $1.1 billion in community resources; and had estimated that it's decisions would generate $1.1 billion in annual health system savings through clinical and administrative efficiencies, rationalisation of services and facility closures. The Auditor's report highlighted the financial assistance that the Ministry provides to hospital corporations. The Ministry's share of eligible restructuring costs is 70% for capital and 85% for operating costs. The remaining costs are the responsibility of the hospital or community.[16] Since 1995, more than $1.7 billion in capital funding has been provided for hospital construction and renovation projects.[17]

The Auditor's Report pointed out that the HSRC's goal was to complete all restructuring capital projects before its mandate expired in 2000. According to more recent Ministry estimates, however, the Ministry anticipates that many projects will not be completed until 2003/04. Moreover, while the HSRC's tally of capital projects was estimated to reach $2.1 billion, the Ministry's own project status report indicated that these project costs could reach $3.9 billion.[18] Health Minister Elizabeth Witmer responded that there have been some struggles. "This province was the very last in Canada to tackle the reform of health care. We undertook to strengthen and improve our system and we have done so."[19]

In late November 1999, the Minister introduced Bill 23, the *Ministry of Health and Long-Term Care Statute Law Amendment Act, 1999*. According to a ministry press release, the

legislation was to ensure that the Minister of Health and Long-Term Care maintained responsibility under Section 6 of the *Public Hospitals Act* for the 22 communities where the Health Services Restructuring Commission issued *Directions*. Without the proposed change, this responsibility would have ended on March 1, 2000, well before most hospitals would have completed their restructuring projects.

Opposition Members expressed concerns about the authority that the legislation provided to the Minister of Health. The government responded that it simply enabled the Minister to enforce the orders already issued to hospitals by the HSRC. The Ontario Hospital Association (OHA) publicly agreed to support the extension of these Section 6 powers, provided that the Minister met several conditions.[20] In the OHA's view, providing the Minister with these powers would give hospitals greater flexibility as they continue with their restructuring efforts. Bill 23 received Third Reading, and in mid-December received Royal Assent.

Hospital and Community Fundraising

In an effort to complete the projects and pay for the improvements ordered by the HSRC, Ontario hospitals and communities embarked upon fundraising campaigns to raise money for the hospital or community's share of restructuring costs. Some observers, including the Canadian Centre of Philanthropy have expressed concerns about the ability of communities to continue giving. It is estimated that half of the province's 164 hospitals are in the midst of fundraising appeals. The Ontario Hospital Association anticipates that communities must raise about $2 billion between 1999 and 2003 to pay for the improvements, and has expressed concern about donor fatigue.

In addition to fundraising, some northern communities such as Sudbury and Thunder Bay have been approached about helping to finance the local share of hospital upgrades and construction through property taxes or a special levy. To ensure that city residents are not overburdened with financing a project of benefit to the entire hospital catchment area, residents of outlying areas have been asked to contribute as well. In response to these funding appeals, some local residents, councillors and mayors have stated that they are not keen to finance the health care projects from a local health tax.[22] They did, however, indicate a willingness to join with other municipalities to press the province to increase its share of financing for provincially-mandated hospital restructuring. In April, Sudbury MPP Rick Bartolucci told the Legislature that Ontarians were advised five years ago that hospital restructuring would generate huge savings. He noted that "Sudburians are now faced with the largest fundraising event in Sudbury's history, the $40 million plus Heart and Soul Campaign."[23] He explained that campaign organizers received $5 million from the Sudbury regional council, but council declined the campaign's request for an additional $23 million, arguing that the provincial government has to take responsibility for these costs. The Member said that Sudbury residents strongly oppose picking up this multi-million-dollar tab, adding that local politicians and community leaders will be travelling to Queen's Park to ask for additional funds.[24]

The northern press reported that the Federation of Northern Ontario Municipalities (FONOM) would appeal to the Province for more funds to pay for hospital restructuring.

According to Sudbury Mayor Jim Gordon, "while we can see that we are obtaining new state-of-the-art facilities and equipment, it is beyond the capacity of northerners to come up with those kinds of dollars, either from the private sector or the public purse."[25]

END OF THE MANDATE. . .

The HSRC marked the end of its four-year mandate on March 28, 2000 by issuing its final report: *Looking back, looking forward: Seven Points for Action*. The Report reiterated that phase I of the HSRC's mandate focused on hospital restructuring while phase II focussed on how to change, co-ordinate and integrate the many components of health care delivery into a single health services system.[26] In the Commission's view, phase II has been more of a challenge and the work more significant. The final report talked about achieving a shared vision for a health care system and moving the system forward. Building on its vision of the future health system the Commission provided a seven-point action plan buttressed by action strategies.

Action 1	Build on the implementation of hospital restructuring and reinvestment in other health facilities and community services.
Action 2	Articulate, confirm and communicate a vision of the future health services system in Ontario.
Action 3	Clarify and define the role of government as primarily responsible for system governance and leadership.
Action 4	Develop a comprehensive health information management system.
Action 5	Implement a new model providing comprehensive primary health care
Action 6	Foster and support greater integration and co-ordination within and across the system by: • Building on community efforts to strengthen integration. • Strengthening academic health science centre networks.
Action 7	Develop and implement a strategy for improving system accountability and health system performance.

. . . But not the Work

In its concluding remarks, the Commission's *Seven Points for Action* report urged the government to appoint an independent, arms-length 'entity' to act as a buffer between the government and the fallout from the difficult decisions that have to be made if Ontario is to stay the course of change.

In the closing words of its final report, the Commission remarked that its mandate may be over but the work must continue:

> Ontario realized four years ago that action had to be taken on reform of the health system, a much-discussed topic long delayed. The government showed great courage and initiative in creating and giving the power to effect change in the hospital sector to the Health Services Restructuring Commission. It has supported the Commission's decisions and acted decisively on the majority of its recommendations, especially those related to massive expansion of long-term and home care throughout the province.
>
> The HSRC's final message as it leaves the scene is, there is much left to do. And the time is short in which to create the genuine system of health and health care services needed to meet the needs of the population into the 21st century. Now is not a time for Ontario to rest on the oars. We need to keep rowing – hard![27]

Assessing the Commission's Work

During a press interview, Duncan Sinclair, former chairman of the Health Services Restructuring Commission highlighted an intriguing lesson learned about the process. He observed that hospital restructuring should have come toward the end rather than the start of the health care reforms.

> (One should) begin with primary-care reform and the creation of information-management capability and then get the hospitals, (which) live at the end of the line when people are very ill. . . .If we had started the other way round, I would feel better right now."[28]

The Ontario Legislature re-convened on 3 April 2000, six days after the Commission wrapped up. Legislative commentary about the winding up of the HSRC and its significance over the past four years focused less upon hospital restructuring and more upon questioning the government's approach to primary care reform which was phase II of the Commission's mandate.[29]

Reflection on the Commission's work was eclipsed by a larger health care debate unfolding on the national scene. Much sparring occurred (and continues) between the federal and provincial governments in the wake of the Federal Budget of February 28, 2000 which announced a one-time allocation of $2.5 billion to the provinces for post-secondary education and health care. Provinces had been seeking an extra $4.2 billion annual increase to restore federal funding to 1994 levels.[30]

A sampling of media commentary reveals that responses to both the Commission's final report and its legacy were mixed. The *Ottawa Citizen* argued that while some of the activities of the HSRC were commendable, it ultimately could not do the job. The

Citizen expressed relief that responsibility for the public health care system is now back where it belongs – with the government.[31]

The *Toronto Star* characterized the Commission's final two years as frustrating – getting bogged down in legal challenges and attempts to redesign a health system for the future. "Most of the hospitals it ordered closed remain open and will for several years. A third of the province's hospitals are struggling with deficits. And the slow pace of reforms has many worried that Ontarians are going to suffer from the disruption for years to come. . . Of 43 hospitals – 31 acute-care, six psychiatric and six private – ordered closed, only five have shut their doors. Most won't be closed for another three or four years."[32] According to the government (November 30, 1999), the HSRC has issued more than 1,200 separate directions for hospital improvements where target completion dates extend beyond the year 2000. Hospitals in 22 communities across Ontario are in the process of putting in place the expanded and improved health care services. As of late November 1999 the government had already invested more than $1.2 billion in hospital restructuring, and was planning to invest a total of $3.2 billion.[33]

In an editorial, however, the *Toronto Star* expressed support for the general thrust of the Commission's recommendations but added three strong reservations. First, it would be unwise to close hospitals until nursing home beds are available. Second, Queen's Park should encourage rather than compel primary care reform. Third, the government would be foolish to extract any more savings from hospitals as one-third are already borrowing to cover their expenses. In the *Star's* view, "The commission tackled a tough, politically sensitive job and did it unflinchingly. It took the blame for many of the problems caused by the Harris government's spending cuts and reluctance to invest in new health-care facilities. It provoked a badly-needed public debate."[34]

The *Toronto Sun* observed that while the government was courageous to establish the HSRC, the fact that it is necessary to establish an independent commission to do what the government cannot do itself is a sad commentary on how democracy works in Canada. "You can't do the tough stuff like closing a vital community asset and get re-elected."[35]

A columnist from the *Ottawa Sun* suggested that Ontarians should heed the warning in the Commission's final report about the perils of complacency. "If the province doesn't move – and fast – to rationalize the system, it will be too late. . . Perhaps we should take a moment to thank Sinclair and his team. They took on the most unenviable task the government faced, and they did so gladly, not out of political ambition, but to perform a valuable public service – the salvation of our health care system."[36]

A *Hamilton Spectator* editorial agreed with the need for major reform, including the closure of high-cost hospital infrastructure where necessary. But it expressed criticism toward the "unaccountable Health Services Restructuring Commission," and the "arbitrary authority" given to them. The editorial also asserted that the government was too slow to open long-term care beds, make home care available and reform primary care.[37]

CONCLUSION

Hospital restructuring is just one piece of the larger health care reform puzzle, but it is an important component. The public perceives hospitals as a commanding symbol of health care. The Health Services Restructuring Commission understood the degree to which people are attached to their community hospitals, and was not surprised by the public anxiety resulting from their *Directions*.

The key outcomes of hospital restructuring expected to be in place by 2003/04 include: cost-effectiveness, accessible services and higher quality patient care. The degree of success in obtaining these outcomes will be more evident as 2003 draws nearer. A favourable result will be linked, in part, to whether other health care system reforms (primary care, long-term care, mental health, integrated information management) meet their objectives and whether investments in necessary physical facilities and community resources are completed. Perhaps then, hospitals can begin to reap the savings from clinical and administrative efficiencies.[38]

Until 2003/04, the hospital system of Ontario will face continuing challenges. While hospitals have received (and will continue to receive) considerable public funds (both permanent increases to annual base funding and one-time funding), many hospitals are currently operating with a deficit. Moreover, some communities have expressed doubts about their ability to raise the millions of dollars required for their share of restructuring costs. While the objectives of hospital restructuring in Ontario were at least partially geared to achieving savings by eliminating inefficiency, waste and duplication, the exercise has demonstrated that health care reform is not cheap. It requires significant investments. This fact is well known to Provincial and Territorial Health Ministers and Premiers and was highlighted in a recent report[39] suggesting that publicly-funded health care costs in Canada could almost double within ten years. The public should anticipate more federal-provincial dialogue as provincial and territorial leaders call upon the federal government to help finance these costly system reforms.

NOTES

[1] Ontario, Health Services Restructuring Commission, *Looking back, Looking forward, Seven Points for Action* (Toronto: The Commission, March 2000). Internet site at http://www.hsrc-crss.org/e_menu_p2r.htm accessed on 30 March 2000.
[2] Ontario, Provincial Auditor, *Annual Report 1999*. Internet site at http://www.gov.on.ca/opa/en99/en99.html/309en99.html accessed on 12 April 2000.
[3] See Metropolitan Toronto District Health Council, *Directions for Change: Toward a Co-ordinated Hospital System for Metro Toronto, Final Report of the MTDHC Hospital Restructuring Committee* (Toronto: The Council, September 29, 1995).
[4] The Ministry introduced transition funding programs in the 1998/99 fiscal year to provide financial assistance to hospitals facing short-term financial pressures. *1999 Report of the Provincial Auditor*. Internet site at http://www.gov.on.ca/opa/en99/en99.html/309en99.html accessed on 12 April 2000.
[5] Responding to requests from the Ontario Hospital Association, Minister of Health Jim Wilson told the Committee studying Bill 26 that government was providing hospitals with the following toolkit: more certainty with respect to hospital financial planning by setting three-year financial reduction targets at four, five and seven %; a pledge that funding not be reduced 'across the board' but contain a differential to recognize small and high-growth hospitals; government agreed to allow hospitals to establish crown foundations in order to solicit charitable donations; government also agreed to develop guidelines for arbitrators instructing them to consider employers' ability to pay salary and wage increases; government would also allow hospitals the means to raise revenues within *Canada Health Act* parameters. *Notes for Remarks by the Honourable Jim Wilson, Minister of Health, on Bill 26 to Committee*, 18 December 1995, pp. 8-9.
[6] Insight Information Inc., *Health Care Services: Implementing the New Agenda* (Toronto: Insight Information, 1996), p. 19.
[7] Ibid.
[8] In the words of the Commission, hospital restructuring has created much anxiety among health care professionals, hospital staff and the general public. Its April 1999 report noted that people are understandably attached to their community hospitals. After all, hospitals are where most of their children are born, where personal and family emergencies are dealt with, and where their last days are often spent. Ontario, Health Services Restructuring Commission, *Better Hospitals, Better Health Care for the Future: Summary Report on Hospital Restructuring 1996-1999*, (Toronto: The Commission, April 1999). Internet site at http://www.hsrc-crss.org/bettere/2.html accessed on 31 January 2000.
[9] Press reports of the Provincial Auditor's Queen's Park news conference held November 16, 1999 at the release of his *1999 Annual Report*, "Hospitals estimate that capital costs to restructure hospitals will be $1.8 billion higher than the Health Services Restructuring Commission's estimate of $2.1 billion." In response to the Auditor's assertion that hospital restructuring was four years behind schedule and could go over budget by $1.8 billion, Health Minister Elizabeth Witmer commented: "He has taken the absolute worst-case scenario. Our estimates continue to be right on target." See: Jeff Harder, "Health-

care overhaul could cost $1.8 B more: The Auditor's report," *London Free Press*, 17 November 1999.

[10] Health Services Restructuring Commission, "Commission Set to Release Revised Reinvestment Guidelines," *Media Advisory*, 6 April 1998.

[11] Health Services Restructuring Commission, "HSRC Recommends $900 Million Annual Reinvestment in Health system by 2003," *News Release*, 27 April 1998.

[12] The Framework was intended to guide hospitals, health care providers, district health councils, the Ministry and the HSRC in planning and decision-making. Moreover, the framework would make it easier for small communities to recruit and retain physicians and other health care professionals, and would lead to closer ties between small hospitals and community-based services. Ontario, Ministry of Health, "New Rural and Northern Health Care Framework to Provide 24-Hour Access to Care," *News Release and Backgrounder*, 27 June 1997.

[13] On September 4, 1997, the Minister announced that the 33 DHCs would be merged into 16 by the end of the year.

[14] The HSRC's April 1999 summary report was entitled *Better Hospitals, Better Health Care for the Future*.

[15] Ibid.

[16] Ontario, Office of the Provincial Auditor, *1999 Provincial Auditor's Annual Report*. Internet site at http://www.gov.on.ca/opa/en99/en99.html/309en99.html accessed on April 12, 2000.

[17] "Ontario invests $6.8 million for new services at Grand River Hospital," *Government of Ontario Press Release*, 13 June 2000.

[18] Ibid.

[19] Jeff Harder, "Health-care overhaul could cost $1.8B more, the Auditor's Report," *London Free Press*, 17 November 1999.

[20] According to a November 30th 1999 OHA News Release, the OHA agreed to an extension of these powers to the Minister provided that the powers in Section 6 would apply only to those hospitals to which the HSRC has already issued 1,200 directions; that a thorough public review process take place prior to January 1, 2005 if any powers under Section 6 are to be retained beyond 2005; that the Minister not delegate these powers to any other person or body; that an advisory body, comprised of government and hospital representatives, be established to advise the government on any substantive changes to restructuring directions.

[21] Government of Ontario Press Releases, "Government provides flexibility for hospital restructuring timelines," 30 November 1999. Internet site at http://www.newswire.ca/government/ontario/english/releases/November1999/30/c9371.html accessed on 22 February 2000.

[22] Terry Pender, "Councillor questions fund-raising campaign," *Sudbury Star*, 25 April, p.A1.

[23] The *Sudbury Star* reported in July 2000 that the community's Heart and Soul Campaign aims to raise $17.5 million locally to help pay for three health-care projects that will cost a combined $210 million – the Sudbury Regional Hospital expansion, an expansion of the Northeastern Ontario Regional Cancer Centre and the creation of a long-term care facility at St. Joseph's Health Centre. The $17.5 million represents a fraction of funds needed to pay for the three health care projects. In total, about $70 million,

perhaps more, remains to be found from fund-raising, from local taxpayers, from institutional fees and revenues and from various sources of government funding. About three-quarters of that total is needed by the regional hospital. Denis St. Pierre, "Health-care fund-raising campaign set to start: Heart and Soul volunteers training for launch of drive in September," *Sudbury Star*, 4 July 2000, p. A1.

[24] Ontario, Legislative Assembly, *Hansard: Official Report of Debates* 37th Parliament, 1st Session, 4 April 2000. Internet site at http://hansardindex.ontla.on.ca/hansardeissue/37-1/1036.htm accessed on 28 April 2000.

[25] Terry Pender, "Ads irritate councillors lobbying for hospital cash: Committee OKs plan to lobby province to pay more of hospital restructuring costs," *Sudbury Star*, 19 April 2000, p. A.1.

[26] At the conclusion of his mandate, Duncan Sinclair gave a press interview and told the Sun's editorial board that. "We do not have a system now. We have a lot of excellent players. They don't work together worth a hoot to achieve synergy." See: John Downing, "HSRC closes shop with hope for future but the work of reforming health care has really just begun, says commission's head," *Toronto Sun*, 29 March 2000.

[27] Ontario, Health Services Restructuring Commission, *Looking back, looking forward, Seven Points for Action* (Toronto: The Commission, March 2000).

[28] "Health Reform criticized," *(Sarnia) Observer*, 28 March 2000, p.A1.

[29] A government official confirmed to the press on March 28, 2000, that primary care reform will proceed on a voluntary basis. The HSRC had advised in December 1999 that Primary Care Groups be developed over the next six years in Ontario, and that it be mandatory. According to Barry Wilson, Press Secretary to Elizabeth Witmer, "We fully intend to expand primary care reform based on the following three principles: that it remains voluntary for patients and physicians, that patients will have the freedom to choose their provider and change providers if they wish. And that the new system must be properly evaluated to ensure that it is delivering the highest quality care and the highest patient safety possible." See: Theresa Boyle, "Health Care reform: Tories give in; Patients won't be obliged to see just one doctor," *Toronto Star*, 28 March 2000. Opposition Party leaders Dalton McGuinty and Howard Hampton told the Legislature that the government, in the midst of negotiations with the OMA, was not moving fast enough on primary care reform. Health Minister Elizabeth Witmer responded that primary care pilot sites have been expanded from five to seven. She reiterated that primary care would proceed on a voluntary basis for patients and practitioners and would be followed by an evaluation. Premier Harris responded that while primary care reform is important, it costs money and Ontario needs help from the federal government. Ontario, Legislative Assembly, *Hansard: Official Report of Debates*, 37th Parliament, 1st Session, 3 April 2000. Internet site at http://bb/hansard/37_parl/session/L035_1.htm accessed on 7 April 2000.

[30] This larger debate over the funding of Canada's health care commenced in late January 2000 when federal health minister Allan Rock proposed to overhaul elements of Canada's health care system. Several provincial premiers took the federal government to task for reducing federal transfers, particularly since 1994. They argued for full restoration of federal transfers back to 1994 levels, the year when federal Finance Minister Paul Martin began cutting. The February 28, 2000 federal budget did not meet provincial expectations. Since the February federal budget, there has been much debate

between the provinces and the federal government over who is funding the health care system and by how much. On March 24th, the Ontario government launched a $3 million television advertising campaign to illustrate its claim that Ottawa pays only 11 cents on the health care dollar while Ontario pays the rest. The federal government responded that its contribution is 34 cents rather than 11 cents, and on April 17, countered with television ads of its own. Ontario then launched a new round of television ads at an estimated cost of $5 million. Premier Mike Harris responded that he would end the advertising campaign once the federal government restores $1.7 billion in transfers for health care. Ontario Opposition critics argue that the "ad war" is wasting taxpayers money, worsening relations between Ottawa and Ontario, and doing nothing for health care. See: Tom Blackwell, "Another $2 million injected into health ads," *National Post*, 20 April 2000, p. A.21.

[31] "A return to healthy democracy," *Ottawa Citizen*, 5 April 2000, D.4.

[32] Rita Daly, "Health services group leaves reforms undone; Disruption predicted for years to come," *Toronto Star*, 1 April 2000.

[33] Government of Ontario Press Releases, "Government provides flexibility for hospital restructuring timelines," 30 November 1999. Internet site at http://www.newswire.ca/government/ontario/english/releases/November1999/30/c9371.html accessed on 22 February 2000.

[34] "Health commission ends stormy tenure," *Toronto Star*, 29 March 2000.

[35] John Downing, "HSRC closes shop with hope for future but the work of reforming health care has really just begun, says commission's head," *Toronto Sun*, 29 March 2000.

[36] Christina Blizzard, "Health care cure has only just begun," *Ottawa Sun*, 29 March 2000.

[37] "What we think: the Spectator's views on key issues," *Hamilton Spectator*, 29 March, 2000.

[38] Ontario, Provincial Auditor, *Annual Report 1999*, Ministry of Health and Long-term Care, "Institutional Health Program – Transfer Payments to Public Hospitals." Internet site at http://www.gov.on.ca/opa/en99/en99.html/309en99.html accessed on 12 April 2000.

[39] Provincial and Territorial Minister of Health, *Understanding Canada's Health Care Costs*, Interim Report (June 2000).